Appendix E: Intensive Community Based Support

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Definitions

“ACT Service Coordination” means a process of organization and coordination within the multidisciplinary team to carry out the range of treatment, rehabilitation, and support services each client expects to receive per his or her written individualized treatment plan and is respectful of the individual’s wishes. Service coordination also includes coordination with community and vocational resources, including housing resources, consumer self-help and access to advocacy organizations that promote recovery.

“Care Coordination” means locating and coordinating services across multiple providers to include sharing of information among health care providers, and others who are involved with an individual's health care, to improve the restorative care and align service plans.

“Crisis Intervention” means behavioral health care, available 24-hours per day, seven days per week, to provide immediate assistance to individuals experiencing acute behavioral health problems that require immediate intervention to stabilize and prevent harm and higher level of acuity.

“Health Literacy Counseling” means patient counseling on mental health, and, as appropriate, addiction, treatment, and recovery, and associated health risks including administration of medication, monitoring for adverse side effects or results of that medication, counseling on the role of prescription medications and their effects including side effects and the importance of compliance and adherence.

“Peer Recovery Support Services” means strategies and activities that include person centered, strength based planning to promote the development of self-advocacy skills; empowering the individual to take a proactive role in the development of their plan of care; crisis support; assisting in the use of positive self-management techniques, problem-solving skills, coping mechanisms, symptom management and communication strategies identified

in the plan of care. Caregivers of individuals under age 21 may also receive family support partners as a peer recovery support service when the service is directed exclusively toward the benefit of the individual. Caregivers of individuals under age 21 may also receive family support partners as a peer recovery support service when the service is directed exclusively toward the benefit of the individual.

“Skills Restoration” means a service to assist individuals in the restoration of lost skills that are necessary to achieve the goals established in the individual’s plan of care. Services include assisting the individual in restoring the following skills: self- management, symptom management, interpersonal, communication, community living, and problem solving skills through modeling, coaching, and cueing.

The following definitions found in Chapter II of this manual, apply to this Appendix:

- Certified substance abuse counseling assistant (CSAC-A)
- Certified substance abuse counselor (CSAC)
- Certified substance abuse counselor supervisee (CSAC supervisee)
- Credentialed addiction treatment professional (CATP)
- Licensed mental health professional (LMHP)
- LMHP-resident (LMHP-R)
- LMHP-resident in psychology (LMHP-RP)
- LMHP-supervisee in social work (LMHP-S)
- Registered Peer Recovery Specialist
- Qualified mental health professional-adult (QMHP-A)
- QMHP-eligible (QMHP-E)
- Qualified paraprofessional in mental health (QPPMH)

The following definitions found in Chapter IV of this manual, apply to this Appendix:

- Assessment
- Care Coordination
- Comprehensive Needs Assessment
- Counseling
- Individual Service Plan (ISP)
- Psychoeducation
- Treatment Planning

Assertive Community Treatment (ACT)

ACT Level of Care Guidelines	
Service Definition	Assertive Community Treatment (ACT) provides long term needed treatment, rehabilitation, and support services to identified individuals with severe and persistent mental illness especially those who have severe symptoms that are not effectively remedied by available treatments or who because of reasons related to their mental illness resist or avoid involvement with mental health services in the community. ACT services are offered to outpatients outside of clinic, hospital, or program office settings for individuals who are best served in the community. ACT is a highly coordinated set of services offered by group of medical, behavioral health, peer recovery support providers and rehabilitation professionals in the community who work as a team to meet the complex needs of individuals with severe and persistent mental illness. An individual who is appropriate for ACT requires this comprehensive, coordinated approach as opposed to participating in services across multiple, disconnected providers, to minimize risk of hospitalization, homelessness, substance use, victimization, and incarceration. An ACT team provides person-centered services addressing the breadth of individuals' needs, and is oriented around individuals' personal goals. A fundamental charge of ACT is to be the first-line (and generally sole provider) of all the services that an individual receiving ACT needs. Being the single point of responsibility necessitates a higher frequency and intensity of community-based contacts between the team and individual, and a very low individual-to-staff ratio. ACT services are flexible; teams offer personalized levels of care for all individuals participating in ACT, adjusting service levels to reflect needs as they change over time.

Critical Features & Service Components	An ACT team assists individuals in advancing toward personal goals with a focus on enhancing community integration and regaining valued roles (e.g. worker, daughter, resident, spouse, tenant, or friend). Because an ACT team often works with individuals who may demonstrate passive or active resistance to participation in services, an ACT team must carry out thoughtfully planned assertive engagement techniques including rapport-building strategies, facilitating the individual in meeting basic needs, and motivational interviewing interventions. The team uses these techniques to identify and focus on individuals' life goals and motivations to change. Likewise, it is the team's responsibility to monitor individuals' mental status and provide needed supports in a manner consistent with their level of need and functioning. The ACT team delivers all services according to a recovery-based philosophy of care. Individuals receiving ACT should also be engaged in a shared decision-making model, assistance with accessing medication, medication education, and assistance in medication to support skills in taking medication with greater independence. The team promotes self-determination, respects the person participating in ACT as an individual in their own right, and engages registered peer recovery specialists to promote hope that recovery from mental illness and regaining meaningful roles and relationships in the community are possible. Critical features of ACT include: • ACT staff availability either directly or on-call 24 hours per day, seven days per week and 365 days per year; • Crisis response and intervention that is available 24 hours per day, seven days per week and 365 days per year, including telephone and face-to face contact; • Team is to be the first line (and generally sole provider) of all the services that individuals may need by providing individualized, intensive treatment/rehabilitation and support services in the community; • Team develops and has access to each individual's individualized crisis plan and the team has the capacity to directly engage with each individual to help directly address emerging crisis incidents and to support stabilization; • Team provides a higher frequency and intensity of community-based contacts with a staff-to-individual ratio no greater than 1:9; and • Team provides services that are community based, flexible and appropriately adjusted based on the individuals evolving needs. ACT teams must offer and have the capacity to provide the following covered service components to address the treatment needs identified in the initial comprehensive needs assessment: • Assessment and treatment planning • Integrated dual disorders treatment for co-occurring substance use* • Crisis assessment and treatment/intervention • Health literacy counseling • Medication management • Skills restoration/development - Social Skills - Wellness self-management and prevention - Symptom management - Skills required for activities of daily and community living • Peer recovery support services;* • Empirically supported therapeutic interventions & therapies;* • ACT service coordination (care coordination) consisting of facilitating access to: • Employment and vocational services • Housing access & support • Other services based on client needs as identified in the Individualized Service Plan (ISP) *As clinically indicated and supported by staff capacity and client engagement, these services components can be provided in an individual and/or group setting.

Required Activities	The following required activities apply to ACT: • At the start of services, a LMHP, LMHP-R, LMHP-RP, LMHP-S, Nurse Practitioner or Physician Assistant shall conduct an initial assessment consistent with the components required in the Comprehensive Needs Assessment (see Chapter IV for requirements), documenting the individual's diagnosis/es and describing how service needs match the level of care criteria. If a nurse practitioner who is not a psychiatric/mental health nurse practitioner or a physician assistant conducts the initial assessment it can only be used as the assessment for ACT and cannot be used as a comprehensive needs assessment by the provider for other mental health services (see Chapter IV for details). • Individual Service Plans (ISPs see Chapter IV for requirements) shall be required during the entire duration of services and must be current. The initial treatment plan (ISP) shall be completed on the day of admission to the service. The treatment planning process should be collaborative but must be directed and authorized by a LMHP, LMHP-R, LMHP-RP, LMHP-S, nurse practitioner or physician assistant. • ISPs must be reviewed as necessary at a minimum of every 30 calendar days or more frequently depending on the individual's needs. Refer to Chapter IV for additional guidance and documentation requirements for the 30 calendar day review as well as additional quarterly review requirements. • Medication prescription monitoring must be provided by a psychiatrist or psychiatric nurse practitioner who completes a psychiatric evaluation on the day of admission and has contact with individuals on a quarterly basis. • For individuals with a co-occurring substance use diagnosis, the ACT team will provide individual and group modalities for dual disorders treatment based on the principles of Integrated Dual Disorder Treatment and aligned with the individual's readiness/stage of change. In addition, the ACT team will provide active substance use counseling and relapse prevention, as well as substance use education. • Registered peer recovery support specialists shall be a part of the ACT team with services to include coaching, consulting, wellness management and recovery strategies to promote recovery and self-direction. Registered peer recovery support specialists may also model and provide education on recovery principles and strategies to fellow team members. • If the individual consistently deviates from the required services in the ISP, the provider should work with the Managed Care Organization (MCO) or the fee for service (FFS) contractor to reassess for another level of care or model to better meet the individual's needs. • Providers must follow all requirements for care coordination (See Care Coordination Requirements of Mental Health Providers section of Chapter IV).

Service Limitations	In addition to the "Non-Reimbursable Activities for all Mental Health Services" section in Chapter IV, the following service limitations apply: • An individual can participate in ACT services with only one ACT team at a time. • Group therapy by LMHPs, LMHP-Rs, LMHP-RPs, LMHP-Ss and CATPs shall have a recommended maximum limit of 10 individuals in the group. Group size may exceed this limit based on the determination of the professional providing the service. • ACT may not be authorized concurrently with Individual, Group or Family Therapy, Addiction and Recovery Treatment Services (ARTS) and Mental Health (MH) Intensive Outpatient, Outpatient Medication Management, Therapeutic Day Treatment, Intensive In Home Services, Community Stabilization, Mental Health Skill Building, Applied Behavior Analysis, Multisystemic Therapy, Functional Family Therapy, Psychiatric Residential Treatment Facility (PRTF), Therapeutic Group Home (TGH), ARTS Level 3.1-3.7 or Peer Recovery Support Services, as the activities of these services are included in the per diem. Up to a fourteen calendar day service authorization overlap with these services is allowed as individuals are being transitioned to ACT from other behavioral health services. Up to a 31 calendar day service authorization overlap with these services is allowed as individuals are being transitioned from ACT to other behavioral health services (see service authorization section). Office based opioid treatment services (OBOT) and Office Based Addiction Treatment (OBAT) services are allowed simultaneously with ACT. • If an individual is participating in ACT and has a concurrent admission to a Partial Hospitalization Program, the team should conduct close care coordination with those providers to assure alignment of the treatment plan (ISP) and avoid any duplication of services. • Activities that are not authorized for reimbursement include: - Contacts that are not medically necessary. - Time spent doing, attending, or participating in recreational activities. - Services provided to teach academic subjects or as a substitute for educational personnel such as, but not limited to, a teacher, teacher's aide, or an academic tutor. - Child Care services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision. - Respite care. - Transportation for the individual or family. Additional medical transportation for service needs which are not considered part of ACT program services may be covered by the transportation service through the FFS Non-Emergency Medical Transportation Broker or MCO. Medical transportation to ACT providers may be billed to the transportation broker. - Covered services that have not been rendered. - Services rendered that are not in accordance with an approved authorization. - Services not identified on the individual's authorized ACT Treatment Plan. - Services provided without service authorization by the department or its designee. - Services not in compliance with the ACT National Provider Standards and not in compliance with fidelity standards. - Services provided to the individual's family or others involved in the individual's life that are not to the direct benefit of the individual in accordance with the individual's needs and treatment goals identified in the individual's plan of care. - Services provided that are not within the provider's scope of practice. - Anything not included in the approved ACT service description. - Changes made to ACT that do not follow the requirements outlined in the provider contract, this appendix, or ACT fidelity standards. - Any intervention or contact not documented or consistent with the approved treatment/recovery plan goals, objectives, and approved services. - Time spent when the individual is employed and performing the tasks of their job. Note: ACT does include non-job specific vocational training, employment assessments, and ongoing support to maintain employment. ACT may provide the necessary medical services that enable the individual to function in the workplace, including ACT services such as a psychiatrist's or psychologist's treatment, rehabilitation planning, therapy, and counseling or crisis management that enable the individual to remain in and/or function in the workplace.
ACT Provider Participation Requirements	

Provider Qualifications	ACT service providers shall be licensed by DBHDS as a provider of Assertive Community Treatment and credentialed with the individual's Medicaid MCO for individuals enrolled in Medicaid managed care or the Fee for Service (FFS) contractor for individuals in FFS. ACT service providers must follow all general Medicaid provider requirements specified in Chapter II of this manual. *ACT Team Fidelity Standards* ACT Teams are required to undergo the standardized rating process using the Tool for Management of Assertive Community Treatment (TMACT). ACT reimbursement rates are tiered based on the size of the team and fidelity rating status; information on these rates is available in the "Billing Guidance" section of this appendix.

Staff Requirements	ACT service providers shall meet the staff requirements as follows: *ACT Team Sizes* ACT team sizes and definitions as defined herein are consistent with the national standards for the practice. In accordance with ACT fidelity standards, providers in urban locations should implement mid-size to large teams. Providers in more rural locations will likely implement small or mid-size teams as large teams may be impractical in a sparsely populated area. ACT teams should operate from a single home office as opposed to a collection of satellite locations to promote team coordination and collaboration. • Small teams serve a maximum of 50 individuals, with one team member per eight or fewer individuals; • Mid-size teams serve 51-74 individuals, with one team member per nine or fewer individuals; and • Large teams serve 75-120 individuals, with one team member per nine or fewer individuals. To ensure appropriate ACT team development, each new ACT team is recommended to titrate ACT intakes (no more than 4 total per month)* to gradually build up capacity to serve no more than 100–120 individuals (with a 1:9 ratio) and no more than 42–50 individuals (a 1:8 ratio) for smaller teams. Movement of individuals onto (admissions) and off of (discharges) the team caseload may temporarily result in breaches of the maximum caseload; thus, teams shall be expected to maintain an annual average not to exceed 50, 74, and 120 individuals, respectively. *During the 2021 implementation, providers who were previously licensed as Intensive Community Treatment (ICT) teams and contracted with the MCOs or Magellan of Virginia will be allowed to join the network and provide services to their existing caseloads as long as they meet the client to staff ratios as defined above. *ACT Team Composition and Roles* ACT teams should be composed of individuals who have the strong clinical skills, professional qualifications, experience, and competency to provide a full breadth of biopsychosocial rehabilitation services. While all staff shall have some level of competency across disciplines, the team should emphasize areas of individual staff expertise and specialization to fully benefit ACT service participants. As noted in the critical features section, there are some ACT components that are necessary for fidelity to the model but are not currently covered services within the Medicaid program; this discrepancy is also reflected in the team composition. The service components that are eligible for Medicaid reimbursement must be delivered by providers who are Medicaid-approved and within professional scope for those services. For information on team composition, see DBHDS Emergency Regulations, 12VAC35-105-1370 available at https://townhall.virginia.gov/L/ViewXML.cfm?textid=14853. As required by DBHDS Emergency Regulations, a multidisciplinary ACT treatment team is comprised of the following professionals: • Team Leader • Psychiatric Care Provider • Nurse • SUD/Co-Occurring Disorder Specialist • Registered Peer Recovery Specialist • Vocational Specialist (must be QMHP) • Dedicated Office-Based Program Assistant • Generalist Clinical Staff Member Medication prescription monitoring must be provided by a Psychiatrist or Psychiatric Nurse Practitioner who completes an initial assessment and has contact with individuals on a quarterly basis. Medication administration must be provided by a Psychiatrist, Psychiatric Nurse Practitioner or appropriate licensed nursing professional based on ACT team size. Individual, group, and family therapy must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S or CATP. Health literacy counseling /psychoeducational interventions must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, Nurse Practitioner, Physician Assistant, CATP, CSAC*, CSAC Supervisee* or a RN or LPN with at least one year of clinical experience involving medication management. Crisis intervention must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, CATP, QMHP-A, QMHP-E, CSAC*, CSAC Supervisee* or CSAC-A*. Skills restoration / development must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-E or a QPPMH under the supervision of at least a QMHP-A. Care coordination must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, CATP, QMHP-A, QMHP-E, CSAC*, CSAC Supervisee* CSAC-A* or a QPPMH under the supervision of at least a QMHP-A. Peer recovery support services must be provided by a Registered Peer Recovery Specialist. **CSACs, CSAC Supervisees and CSAC-As may only provide services related to substance use disorder treatment per § 54.1-3507.1 and § 54.1-3507.2* RNs, LPNs, and Nurse Practitioners shall hold an active license issued by the Virginia Board of Nursing. Physicians and Physician Assistants shall hold an active license issued by the Virginia Board of Medicine.

ACT Medical Necessity Criteria	
Admission Criteria Diagnosis, Symptoms and Functional Impairment	Individuals must meet all of the following criteria: 1. The individual must be 18 years or older (as required by EPSDT, youth below age 18 may receive ACT if medically necessary); 2. Prior to the start of services, the following must occur: 1. An assessment inclusive of the components of the Comprehensive Needs Assessment shall be completed by a LMHP, LMHP-R, LMHP-RP, LMHP-S, nurse practitioner or physician assistant to document the individual's diagnosis(es) and describe how service needs match the level of care criteria; 2. This assessment must support a diagnosis from the current version of the Diagnostic and Statistical Manual (DSM) that is consistent with a serious and persistent mental illness (i.e. schizophrenia, other psychotic disorders (e.g., schizoaffective disorder), or bipolar disorder). 1. Individuals with psychiatric illnesses that fall outside the serious mental illness definition may be eligible depending on the level of associated long-term disability; in these cases, a Physician letter justifying this exception should accompany the service authorization request. 3. Individual has significant functional impairment as demonstrated by at least one of the following conditions: 1. Significant difficulty in consistent performance of the range of routine tasks required for basic adult functioning in the community (for example, caring for personal business affairs; obtaining medical, legal, and housing services; recognizing and avoiding common dangers or hazards to self and possessions; meeting nutritional needs; attending to personal hygiene) or persistent or recurrent difficulty performing daily living tasks except with significant support or assistance from others such as friends, family, or relatives; 2. Significant difficulty maintaining consistent employment at a self-sustaining level or significant difficulty consistently carrying out the head-of-household responsibilities (such as meal preparation, household tasks, budgeting, or child-care tasks and responsibilities); or 3. Significant difficulty maintaining a safe living situation (for example, repeated evictions or loss of housing or utilities); 4. Individual has one or more of the following problems, which are indicators of continuous high-service needs: 1. High use of acute psychiatric hospital (multiple admissions to or at least one recent long-term stay of 30 days or more in an acute psychiatric hospital inpatient setting within the last two years) or psychiatric emergency services (more than four interventions in the last 12 months); 2. Intractable (persistent or recurrent) severe psychiatric symptoms (affective, psychotic, suicidal, etc.); 3. Coexisting mental health and substance use disorders of significant duration (more than 6 months); 4. High risk or recent history of criminal justice involvement (such as arrest, incarceration, probation) as a result of the individual’s mental health disorder symptoms; 5. Significant difficulty meeting basic survival needs, residing in substandard housing, homelessness, or imminent risk of homelessness as a result of the individual’s mental health disorder symptoms; 6. Residing in an inpatient setting (e.g. state hospital or other psychiatric hospital) or supervised community residence, but clinically assessed to be able to live in a more independent living situation if intensive services are provided; or requiring a residential or institutional placement if more intensive services are not available; and/or 7. Difficulty in consistent participation in traditional office-based outpatient services;
Exclusion Criteria	Individuals meeting any of the following are ineligible for ACT: 1. The individual’s functional impairment is solely a result of a substance use disorder, personality disorder, developmental disability, traumatic brain injury or autism spectrum disorder without a co-occurring psychiatric disorder; 2. The individual is at imminent risk to harming self or others, or sufficient impairment exists that a more intensive level of service is required; 3. The individual’s psychiatric disorder can be effectively treated or recovery process safely maintained at a less intensive level of care; 4. The individual or their authorized representative does not voluntarily consent to admission or treatment, and/or refuses or is unable to participate in all aspects of treatment; 5. The individual requires a level of structure and supervision beyond the scope of the program; 6. The individual has medical conditions or impairments that needs immediate attention; 7. The individual’s primary problem is social, custodial, economic (i.e. housing, family conflict, etc.), or one of physical health without a concurrent major psychiatric disorder meeting criteria for this level of care, or admission is being used as an alternative to incarceration.

Continued Stay Criteria Diagnosis, Symptoms, and Functional Impairment	Continuation of services may be service authorized at one year intervals based on written service-specific provider re-assessment and certification of need by an LMHP. Individuals must meet all of the following: 1. The individual continues to meet admission criteria; 2. Another less intensive level of care would not be adequate to support recovery; 3. ACT participation remains necessary due to continued risk that without the service, the individual is at risk for the following: 1. Compromised engagement in or ability to manage medication in accordance to the treatment plan 2. Increased use of crisis services 3. Inpatient psychiatric hospitalization 4. Decompensation of social and recreational skills (e.g. communication and interpersonal skills, forming and maintaining relationships) 5. Decompensation in functioning related to activities of daily living 6. Fracture or loss in the individual's community supports due to individual's challenges with symptoms and functioning (Health, Legal, Transport, Housing, Finances, etc.) 7. Decompensation of vocational skills or vocational readiness 4. The individualized treatment plan (ISP)includes evidence suggesting that the identified problems are likely to benefit from continued ACT participation and the goals are consistent with the components of this service; 5. The individual's natural supports, as appropriate, (e.g. individually identified-family/guardian/caregiver) are participating in treatment as clinically indicated and appropriate, or engagement efforts are underway; and 6. Coordination of care and discharge planning are documented and ongoing from the day of admission with the goal of transitioning the individual to a less intensive level of care. These efforts should include communication with potential future service providers, community partners, and related resources related to school, occupational or other community functioning.
Discharge Criteria	The philosophy that guides the ACT model underscores that individuals participating in the service are expected to struggle with engagement given the severity of their mental illness. Individuals should therefore not be discharged from the service due to perceived "lack of compliance" with a treatment plan (ISP) or challenges integrating interventions into their lives towards recovery. Rather, discharge should be considered based on the criteria that follow. The individual meets discharge criteria if any of the following are met: • The individual and team determine that ACT services are no longer needed based on the attainment of goals as identified in the ISP and a less intensive level of care would adequately address current goals; • The individual no longer meets admission/continued stay criteria and/or meets criteria for another level of care, either more or less intensive, and that level of care is sufficiently available; • Required consent for treatment is withdrawn or not obtained; • Extenuating circumstances occur that prohibit participation including: 1. Change in the individual's residence to a location outside of the service area 2. The individual becomes incarcerated or hospitalized for a period of a year or more 3. The individual chooses to withdraw from services and documented attempts by the program to re-engage the individual with the service have not been successful. In circumstances where an individual is discharged from ACT because the individual becomes incarcerated or hospitalized, the provider is expected to prioritize these individuals for ACT services upon their anticipated return to the community, as long as the individual consents to returning to this service and ACT remains an appropriate and medically necessary service for the individual's needs.
ACT Service Authorization and Utilization Review	

Service Authorization	ACT requires service authorization and the service providers delivering ACT shall meet the provider qualifications listed above. Providers shall submit service authorization requests within one business day of admission for initial service authorization requests and by the requested start date for continued stay requests. If submitted after the required time frame, the begin date of authorization will be based on the date of receipt. Additional service authorization information is located in Appendix C to this manual. If the psychiatric evaluation required for admission is unable to be conducted on the same day as the comprehensive needs assessment, the provider shall submit the service authorization request within one business day of completing the psychiatric evaluation. If submitted in this timeframe, the MCO or FFS contractor shall honor the date of the comprehensive needs assessment as the start date of services, however, ACT services other than the comprehensive needs assessment or psychiatric evaluation may not be provided until both the comprehensive needs assessment and psychiatric evaluation are completed. In circumstances where a team discharges an individual from ACT to another behavioral health service provider (including another ACT provider) within the team's service area or county, the ACT team should continue to monitor the transition for 31 days to assure that if an individual does not transition with success to these new services, they are able to voluntarily return to the ACT service. During this 31 day period, the ACT Team shall maintain contact with the new provider to monitor the transition in support of that provider's role in the individual's continued recovery and evolving goals. Additional information on service authorization is located in Appendix C of the manual. Service authorization forms and information on Medicaid MCOs processes is located at www.dmas.virginia.gov/for-providers/behavioral-health/training-and-resources/.
Documentation and Utilization Review	Refer to Chapter VI of this manual for documentation and utilization review requirements.

ACT Billing Guidance

One unit of service is one day. To bill the per diem unit, qualified ACT team members must provide, at a minimum, a total of 15 minutes of face to face covered services during the calendar day that the per diem is billed. Care coordination activities provided by a qualified ACT team member must be provided face to face in order to be included in the 15 minute minimum required to bill the per diem.

After hours crisis services by a qualified ACT team member provided through audio only telehealth may be included in the 15 minute minimum required to bill the per diem if the provider determines that the crisis can be safely managed through telephonic services as specified by the individualized crisis plan.

Licensed direct care staff shall provide services within the scope of practice for their license. Practitioners may not bill for services outside of the ACT per diem (H0040) rate while individuals are receiving ACT services.

The Per Diem Rate includes any of the following service components provided by a qualified provider:

- assessment
- treatment planning

- integrated dual disorders treatment for co-occurring substance use;
- health literacy counseling / psychoeducation
- therapy (individual, group and family)
- skills restoration / development
- crisis intervention
- Peer recovery support services;
- Care coordination.
- ACT Service Coordination

Crisis intervention activities provided by the ACT team shall not be reimbursed separately. While the ACT team should be employed whenever possible as the crisis responder, when immediate crisis intervention is clinically required, billing for concurrent Mobile Crisis Response Services (H2011) is allowable. The ACT provider should coordinate care with the Mobile Crisis Response provider.

Coverage of services delivered by telehealth are described in the "Telehealth Services Supplement". MCO contracted providers should consult with the contracted MCOs for their specific policies and requirements for telehealth.

Billing Code	Unit	Description	Notes	Provider Qualifications
H0040 and modifier as appropriate	Per Diem	Assertive Community Treatment	ACT providers may bill only one per diem per individual per day. All other contacts, meetings, travel time, etc. are considered indirect costs and is accounted for in the buildup of the per diem rate.	Service components must be provided by a qualified provider (see Provider qualification and staff requirements section)
H0040 and modifier as appropriate	n/a	Comprehensive Needs Assessment		LMHP, LMHP-R, LMHP-RP, LMHP-S, Nurse Practitioner, Physician Assistant

90791	n/a	Psychiatric Diagnostic Evaluation	This code should be used when a LMHP, LMHP-R, LMHP-RP or LMHP-S conducts the comprehensive needs assessment, determines that the individual does not meet MNC and will not enter the service.	LMHP, LMHP-R, LMHP-RP, LMHP-S,
90792	n/a	Psychiatric Diagnostic Evaluation	This code should be used when a psychiatrist, physician assistant or nurse practitioner conducts the comprehensive needs assessment, determines that the individual does not meet MNC and will not enter the service.	Psychiatrists, Physician Assistants, and Nurse Practitioners

In accordance with 42 CFR § 441.18, individuals must have free choice of case management providers and cannot be required to or prohibited from receiving case management as a condition of receiving a state plan service such as ACT.

Mental health case management (MHCM) is a distinct service and may only be provided by a DBHDS licensed mental health case management provider (see Chapters II and IV of this manual for additional details). Should an individual choose to enroll in MHCM, or any other targeted case management service, along with ACT, the providers of each of these services will need to clearly and substantially document the need for both and documentation must demonstrate that the two services are not being duplicated.

Rates for ACT are tiered by team size and fidelity status, and each combination of these categories has an associated modifier to be used with the ACT billing code to identify the appropriate rate.

Team Size	Fidelity Status	Team Size Standards	Corresponding TMACT Score	Modifier
Large	Base	Team serves between 75-120 individuals, with one team member per nine or fewer individuals	3.4-3.9	none
Medium	Base	Team serves between 51-74 individuals, with one team member per nine or fewer individuals	3.4-3.9	U1
Small	Base	Team serves a maximum of 50 individuals, with one team member per eight or fewer individuals	3.4-3.9	U2
Large	High	Team serves between 75-120 individuals, with one team member per nine or fewer individuals	4.0-5.0	U3
Medium	High	Team serves between 51-74 individuals, with one team member per nine or fewer individuals	4.0-5.0	U4
Small	High	Team serves a maximum of 50 individuals, with one team member per eight or fewer individuals	4.0-5.0	U5